Chapter V

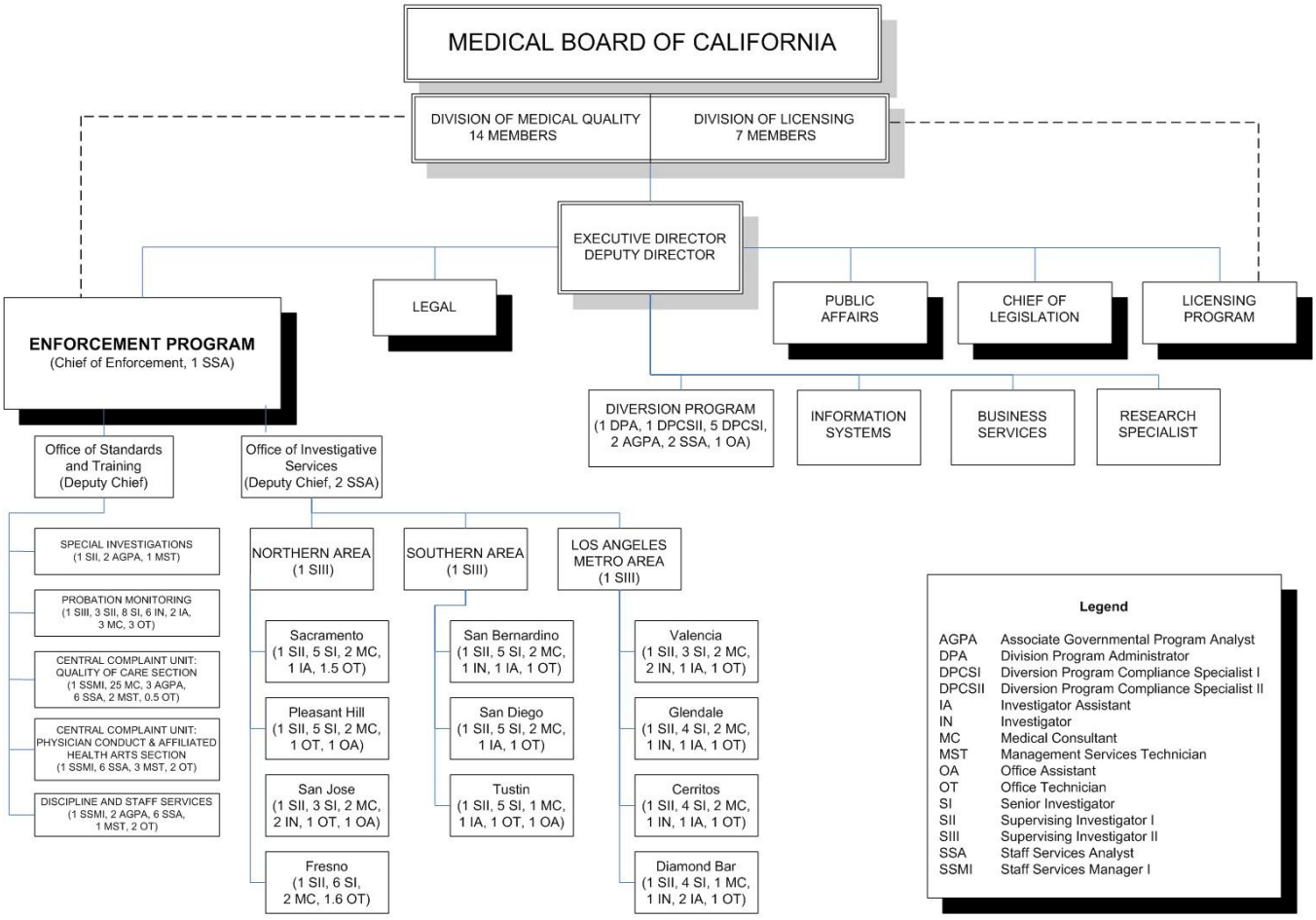
MBC's ENFORCEMENT PROGRAM: GENERAL DESCRIPTION AND THRESHOLD CONCERNS

A. Overview of Function and Updated Data

The Medical Board's enforcement program is complex, fragmented, and expensive. Individuals from three separate agencies participate in its proceedings, and it cost the Board $30 million in 2004–05. Presented here is a brief overview of the various steps of the process — along with an updated enforcement program organizational chart, a flowchart of the pathway of a complaint through the process, and detailed data to give the reader a sense of the complexity of the process and the number of complaints handled by the various participants. We recap several Monitor concerns identified in the *Initial Report* that cut across the entirety of the enforcement program, and discuss steps taken to address those concerns in 2004–05.

Central Complaint Unit. MBC's complaint intake function is centralized in the Central Complaint Unit (CCU) in Sacramento. As reflected in Exhibit V-A below, CCU is presently divided into two sections — the Quality of Care Section (which handles complaints related to diagnosis and/or treatment provided by a physician to a patient in the context of the physician/patient relationship) and the Physician Conduct Section (which handles all other complaints). In most quality of care cases, CCU procures the medical records of the complainant and requests a response or explanation from the subject physician. The medical records and explanation are reviewed by a CCU "medical consultant" (a physician practicing in a similar specialty as the complained-of physician) who recommends whether the matter warrants formal investigation. In non-quality of care cases, CCU may procure medical records and forward them for medical consultant review (if applicable), and/or request a response or explanation from the subject physician; CCU then processes the case as appropriate depending on the type of case and sufficiency of the evidence. Cases that survive CCU screening are referred for formal investigation.

Ex. V-A. MBC Enforcement Program Organizational Chart (September 2005)



Source: Medical Board of California

Field investigations. MBC currently maintains eleven field offices (called "district offices") staffed by professional peace officer investigators, district office medical consultants, and supervising investigators. A case that has survived CCU screening is referred "to the field" in the geographical area where the subject physician practices and is assigned to one of MBC's investigators. Assisted by a medical consultant, the supervising investigator, and a deputy attorney general from the Health Quality Enforcement (HQE) Section of the Attorney General's Office, the investigator develops an investigative plan appropriate to the type of case and conducts the investigation. Investigations typically include the gathering of additional medical records; interviews with the complainant(s), witnesses, and the subject physician; and — in quality of care cases — review of the entire investigative report and the evidence by an "expert reviewer" (again, a licensed physician in the same or similar specialty as the complained-of physician) who opines on the standards of care applicable to the particular matter, whether the subject physician's conduct fell below those standards, in what way(s), and to what degree. If the investigative report and the expert

review indicate that the subject physician has committed a serious and disciplinable violation, the matter is referred to HQE for the drafting of formal charges against the physician's license, and/or (in appropriate cases) to local prosecutors for the filing of criminal charges.

Administrative prosecutions. Once a Medical Board investigator completes an investigative report recommending the filing of disciplinary charges in a given case and that recommendation (often supported by expert testimony) is approved, the matter is transferred to HQE where it is assigned to a deputy attorney general (DAG). The DAG reviews the investigative file and determines whether it is complete and sufficient to prove a disciplinary violation. If so, the DAG prepares an "accusation" (a formal written statement of charges)[63] and returns it to the Medical Board's executive director for approval.[64] The accusation is deemed "filed" when the executive director signs it. The accusation is then served on the subject physician, who is called the "respondent."[65]

The filing of the accusation triggers the adjudication process governed by the Administrative Procedure Act (APA),[66] which is designed to ensure that an accused licensee is afforded appropriate procedural due process before his or her property right (the license) is taken.[67] According to caselaw interpreting the APA, the agency is the moving party, has the burden of proof, and must prove a disciplinary violation by "clear and convincing proof to a reasonable certainty."[68]

Once the accusation is filed, the respondent may file a notice of defense.[69] If such a notice is filed, MBC transfers the case file back to the DAG, who secures a hearing date from the Office of Administrative Hearings (see below). Thereafter, the parties engage in limited discovery[70] and — barring a settlement that is approved by MBC enforcement staff and the Division of Medical Quality — present their respective cases at a public evidentiary hearing presided over by an

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[63] Gov't Code § 11503.

[64] In less serious cases not warranting license revocation, suspension, or probation, MBC may issue a citation and fine, Bus. & Prof. Code § 125.9, or opt to offer the physician a "public letter of reprimand" in lieu of filing or prosecuting an accusation. *Id*. § 2233.

[65] Gov't Code § 11500(c).

[66] *Id*. § 11370 *et seq*.; *see also* Bus. & Prof. Code § 2230(a).

[67] *See*, *e.g*., Gov't Code § 11425.10.

[68] *See*, *e.g*., *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal. App. 3d 853.

[69] Gov't Code § 11506.

[70] *Id*. § 11507.6.

administrative law judge (ALJ) from the Office of Administrative Hearings. At the hearing and throughout any post-hearing proceedings, the HQE DAG represents the Medical Board; the respondent may be represented by private counsel at his/her own expense.

Office of Administrative Hearings' Medical Quality Hearing Panel. The Office of Administrative Hearings (OAH) is a centralized panel of administrative law judges (ALJs) who preside over state and local agency adjudicative hearings in a variety of areas. In 1993, a special panel of ALJs called the Medical Quality Hearing Panel (MQHP) was created in OAH; ALJs appointed to the MQHP are permitted to specialize in physician discipline matters.[71] The law requires an MQHP ALJ to preside over MBC evidentiary hearings.[72]

During the hearing, each party has the right to examine and cross-examine witnesses, present documentary evidence, and present oral argument.[73] Following submission of the evidence, the ALJ prepares a written decision including findings of fact, conclusions of law, and recommended discipline.[74] The ALJ's ruling is a "proposed decision"[75] that is forwarded to the Division of Medical Quality (DMQ), which makes the final agency decision (see below).

In filing charges and recommending discipline, the DAG and the ALJ are guided by a set of "disciplinary guidelines" approved by DMQ; these guidelines set forth the Division's preferred range of sanctions for every given violation of the Medical Practice Act and the Board's regulations.[76]

Division of Medical Quality review. Following completion of the evidentiary hearing, the ALJ's proposed decision is transmitted to MBC headquarters for review by DMQ. For purposes of reviewing ALJ proposed decisions, the fourteen-member DMQ divides into two seven-member panels (Panel A and Panel B); a proposed decision is assigned to one of the panels for review.[77] Within 90 days of receipt of the proposed decision, the assigned DMQ panel must review the ALJ's

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[71] *Id*. § 11371.

[72] *Id*. § 11372.

[73] *Id*. § 11513.

[74] *Id*. § 11425.50.

[75] *Id*. § 11517.

[76] Effective July 1, 1997, Government Code section 11425.50 requires occupational licensing boards to codify their disciplinary guidelines in their regulations. MBC has adopted section 1361, Title 16 of the California Code of Regulations, which incorporates by reference the 2003 version of the Board's disciplinary guidelines.

[77] Bus. & Prof. Code § 2230(b).

ruling and decide whether to "adopt" it as the final agency decision for purposes of judicial review, or "nonadopt" it because it is defective or inappropriate in some way.[78] If the panel nonadopts the ALJ's proposed decision because it believes the penalty should be more severe than that recommended by the ALJ, the panel must order a record of the evidentiary hearing, make it available to both parties,[79] and afford the parties an opportunity for oral argument before the panel prior to deciding the case.[80] In imposing disciplinary sanctions, the DMQ panel must consider the Division's "disciplinary guidelines," which set forth the Division's preferred range of sanctions for every given violation of the Medical Practice Act and the Board's regulations.[81]

Judicial review of DMQ's decision. A physician whose license has been disciplined by DMQ may seek judicial review of the Division's decision by filing a petition for writ of mandate in superior court under Code of Civil Procedure section 1094.5.[82] Generally, the focus of the court's review is to determine whether DMQ's factual findings are supported by the weight of the evidence introduced during the administrative hearing, whether the decision is supported by the findings, and/or whether the penalty imposed is within the agency's discretion or constitutes an abuse of that discretion.[83] Following its review, the superior court may affirm DMQ's decision, or may reverse and/or vacate it and remand it to DMQ for further proceedings.

Either side may challenge the superior court's decision (or any part of the decision) by filing a petition for extraordinary writ in a court of appeal.[84] If the court believes the petition is meritorious, it will grant an alternative writ, order full briefing, entertain oral argument, and issue a written decision. If the court believes the petition is nonmeritorious, it may summarily deny the writ, thus obviating the need for oral argument and a written opinion in the matter.

If the appellate court affirms the superior court's decision, either party may petition the California Supreme Court to review the case. Such review is entirely discretionary and is rarely attempted or granted.

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[78] *Id*. § 2335(c)(3).

[79] Gov't Code § 11517(c)(2)(E).

[80] Bus. & Prof. Code § 2335(c)(4).

[81] *See supra* note 76.

[82] Gov't Code § 11523.

[83] Civ. Proc. Code § 1094.5(b).

[84] Bus. & Prof. Code § 2337.

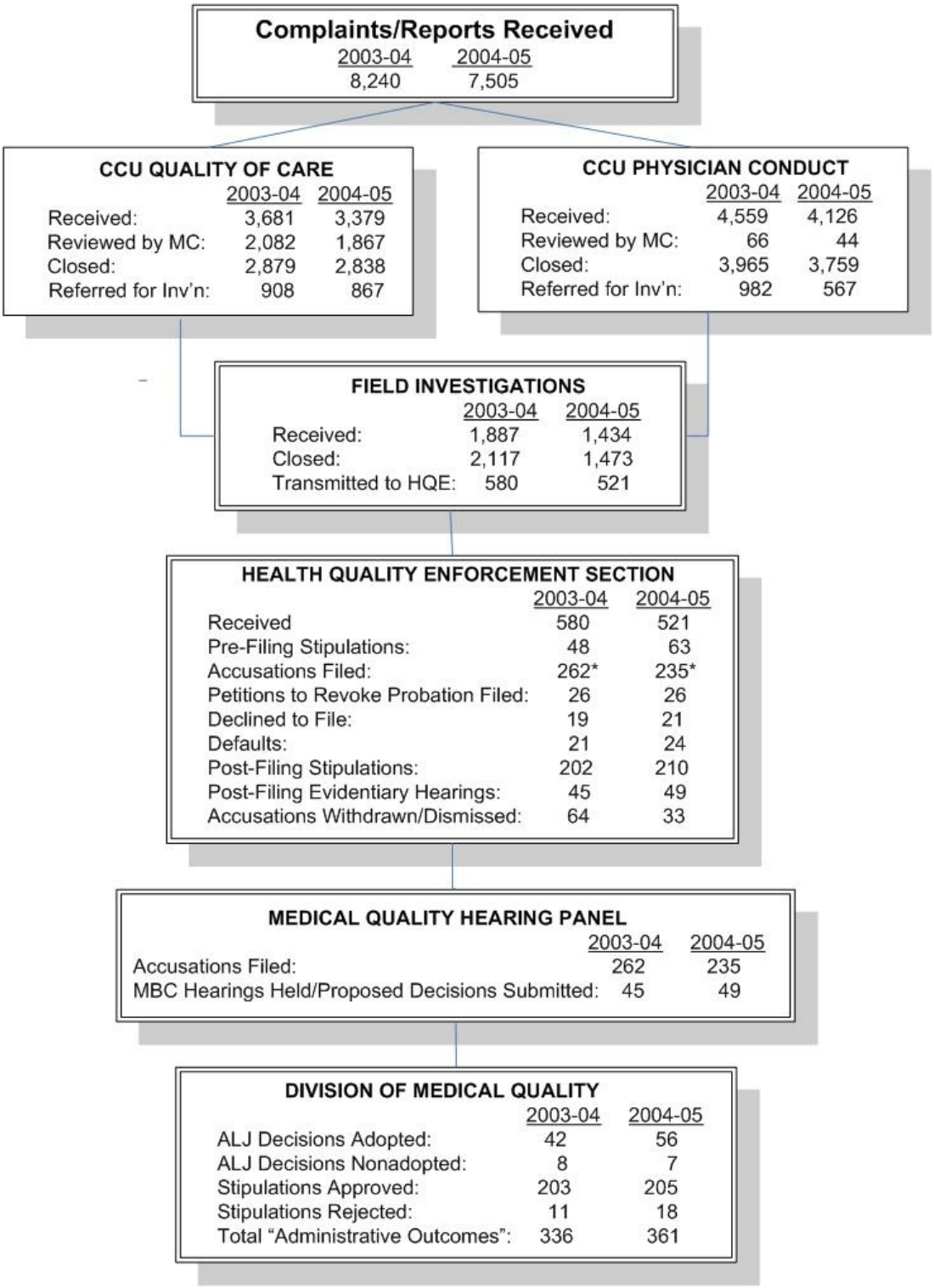
MBC enforcement program flowchart. Exhibit V-B below presents the pathway of a complaint or report of physician misconduct through the MBC enforcement program described above. Additionally, it presents MBC's fiscal year 2003–04 and 2004–05 "throughput" — the number of cases that entered each step and their overall disposition. Exhibit V-C below presents MBC enforcement data from 1991–92 (the year in which HQE was created) to the present.

Exhibit V-B indicates a significant decline in the number of complaints and reports received by MBC and a lower volume of output on the part of MBC and HQE staff during 2004–05. However, a number of variables may be in play, and some explanations are in order:

■ ***Complaint/reports received***. On its face, Exhibit V-B indicates a 9% decline in the number of complaints received in 2004–05 (from 8,240 in 2003–04 to 7,505 in 2004–05). However, MBC adopted one of the Monitor's recommendations and has — in its reported 2004–05 enforcement data — ceased counting so-called "change of address citations" as complaints and investigations.[85] Of the 8,240 complaints and reports received in 2003–04, 327 were change of address citations. Thus, MBC received 7,913 complaints and reports during 2003–04, and there has been an actual 5.2% decrease in the number of complaints received in 2004–05. While this may not be a statistically significant decrease, Exhibit V-C indicates that the decrease reflects a trend occurring over the past three or four years, and it is occurring across almost all sources of complaints and reports, including the valuable reports mandated in Business and Professions Code section 800 *et seq*. Obviously, a downward trend in the number of complaints and reports received helps MBC and its decreased staff — but it may also reflect inadequate public outreach, especially to mandated reporters. These issues are discussed in more detail in Chapters VI and XIV.

[85] A "change of address citation" occurs when MBC's Licensing Unit mails a physician his/her license renewal notice and it is returned to the Board because the address is incorrect — the physician has moved but failed to notify MBC in a timely manner as required by law. When this occurs (and it occurs 300–400 times per year), a complaint is initiated by CCU and it is immediately (on the same day) referred to the Board's Citation and Fine Unit for the issuance of a citation. For some reason, these were counted as both "complaints" and "investigations," although neither CCU nor investigations handled them. The inclusion of "change of address citations" as complaints and investigations artificially skewed MBC's complaint total upward and — because they are opened and closed on the same day — skewed the case cycle times of both CCU and investigations downward. In the *Initial Report*, the Monitor suggested that MBC discontinue counting "change of address citations" as complaints and investigations. *Initial Report*, *supra* note 13, at 98–100 and Recommendation #5. MBC has eliminated them from its 2004–05 reported complaint totals. Medical Board of California, *2004–05 Annual Report* (Oct. 1, 2005) at v.

Ex. V-B. FY 2003–04 and 2004–05 MBC Enforcement Program Throughput



* Multiple cases against the same physician are frequently combined into one accusation.

Source: Medical Board of California

Ex. V-C. Enforcement Program Statistical Profile (Physicians and Surgeons)

	Workload Measure	3-Year Averages 1991-92 through 1993-94	3-Year Averages 1994-95 through 1996-97	3-Year Averages 1994-95 through 1999-00	2000-01	2001-02	2002-03	2003-04	2004-05
Active Licensees		102,680	103,266	106,835	109,289	112,273	115,354	117,806	120,027
Complaint Intake and Review	Complaints Received - B&P Code, Section 800 and 2240(a) Reports	1,010	1,191	1,441	1,538	1,454	1,385	1,240	1,107
	Complaints Received - Govt. & Law Enforcement	NA	1,844	1,855	1,953	1,996	1,737	1,593	1,266
	Complaints Received - Profession	NA	153	270	279	264	295	283	256
	Complaints Received - Public & Other	5,730	3,800	4,046	4,450	4,845	5,478	5,124	4,874
	Total Complaints Received (Excl. NOI and NPDB Reports)	6,740	6,988	7,612	8,220	8,559	8,895	8,240	7,503
	Complaints Closed Without Investigation	4,289	5,616	5,608	5,011	6,818	6,072	6,837	6,603
	Complaints Referred for Investigation (Including Change of Address Citations)	2,608	2,026	2,125	2,320	2,608	2,138	1,887	1,443[a]
	Total Complaints Closed/Referred for Investigation	6,897	7,642	7,734	7,331	9,426	8,210	8,724	8,046
	Pending Complaints (End of Period)	3,397	1,555	1,279	2,229	1,403	2,019	1,566	1,011
Investigation	Investigations Closed or Referred (Including Change of Address Citations)	2,066	2,095	2,304	2,374	2,449	2,361	2,117	1,475[a]
	Referrals to District Attorney (DA) Offices	80	63	70	58	82	47	37	34
	Referrals to Attorney General's Office (AGO)	460	497	595	510	589	494	580	521
	Pending Investigations (End of Period, Excluding Legal Actions)	2,303	1,824	1,406	1,346	1,531	1,251	1,060	1,054
	Pending Investigations Per Investigator (Including AHLP Cases)	33	26	21	18	20	21	18	19
Probation (Including AHLP)	Active, In-State Cases (End of Period)	475	569	500	503	498	516	547	545
	Cases Per Investigator	53	63	42	39	36	40	46	39
	Pending Investigations (End of Period)	69	94	13	35	78	73	43	45
	Pending Legal Action Cases (End of Period)	77	18	37	46	53	39	42	52
	Pending Investigations & Legal Actions Per Investigator	17	12	1	3	6	6	4	7
Legal Actions	TROs/ISOs Ordered	25	28	28	17	26	12	22	29
	Accusations Filed	282	289	327	238	329	258	262	235
	Petitions to Revoke Probation Filed	10	15	31	18	21	18	26	26
	Accusations Withdrawn/Dismissed	33	75	88	54	48	45	64	33
	Pending Legal Actions (End of Period; Including AHLP; Excluding Probation)	584	572	496	547	655	608	494	503
	Pending Legal Actions Per Investigator (Including AHLP Cases)	23	8	7	7	9	10	8	9
Disciplinary Actions	Citations and Administrative Fines Issued	NA	141	290	513	520	532	423	307
	Revocation	51	59	50	39	38	40	37	43
	Surrender	29	67	77	49	47	67	65	82
	Suspension	0	1	2	5	6	4	2	0
	Suspension and Probation	29	30	16	16	19	27	31	17
	Probation Only	51	127	109	91	69	87	98	93
	Public Reprimand	NA	44	50	50	52	58	51	75
	Total, Excluding Citations	162	328	304	250	231	283	284	310
B&P Mandated Reports	Sections 801/801.1/803.2 - Malpractice Reporting by Insurers & Employers	746	894	1,024	921	872	872	787	722
	Section 802 - Malpractice Self-Reporting	79	130	232	391	313	281	228	212
	Section 803 - Malpractice Reporting by Courts	10	21	26	25	30	16	3	9
	Section 802.5 - Coroner Reports of Gross Negligence	16	9	32	33	38	24	18	23
	Sections 802.1/803.5 - Criminal Charges and Convictions	0	18	26	37	38	24	33	20
	Section 805 - Health Care Facilities (Competence)	159	119	101	124	151	162	157	110
	Section 2240(a) - Self-Reported Surgical Death/Complications	0	0	0	7	12	6	14	11
	Total B&P Mandated Reports	1,010	1,191	1,441	1,538	1,454	1,385	1,240	1,107

[a] Effective in FY 2004–05, change of address citations are no longer counted as complaints or investigations.

Sources: Medical Board of California Annual Reports, California Department of Consumer Affairs Annual Statistical Profiles, and MBC Complaint Tracking System data.

■ ***Cases referred for investigation***. Once again, Exhibit V-B indicates a 24% decrease in the number of complaints referred for investigation (from 1,887 in 2003–04 to 1,434 in 2004–05). However, the 2003–04 figure includes 327 change of address citations, so that number should be adjusted to 1,560. In 2004–05, there was an actual 8% decrease in the number of cases sent to the field. The reasons for this decline are unclear. For example, CCU (including the relatively recent additions of a half-time deputy attorney general and supervising investigator, who are reviewing proposed dispositions of many cases) may be doing a better job of screening weak cases away from MBC's depleted investigative staff. It appears that the new "specialty review" requirement mandated

by Business and Professions Code section 2220.08 is not the reason for this decline; this issue is discussed in more detail in Chapter VI.

■ ***Physician conduct cases referred for investigation***. At first look, Exhibit V-B indicates a 42% decrease in the number of physician conduct cases referred to the field in 2004–05 (from 982 to 567). However, the 2003–04 figure must be adjusted to exclude 327 change of address citations. Thus there was an actual decrease of 13% in the number of physician conduct cases referred for investigation.

■ ***Cases closed by investigators***. The number of cases closed by investigators dropped by 317 in 2004–05 (from 1,790 in 2003–04 to 1,473 in 2004–05, when the 2003–04 total is properly adjusted for 327 change of address citations — see above), reflecting a 17.7% decrease.

■ ***Cases forwarded to HQE and accusations filed***. Exhibit V-B reflects a 10% decrease in number of cases sent to HQE (from 580 to 521) and a 10% decrease in the number of accusations filed (from 262 to 235) during 2004–05.

B. The Monitor's Findings and MBC/Legislative Responses

The following summarizes several threshold concerns about the overall enforcement program discussed in the *Initial Report*, and documents the responses to those findings implemented by the Medical Board, the Attorney General's Office, and the Legislature. More detail on each of the findings is available in Chapter V of the *Initial Report*.[86]

1. The enforcement process simply takes too long to protect the public.

During 2003–04, the average length of time for a serious complaint to reach its disciplinary conclusion was 2.63 years. This is an average, and does not include time consumed by judicial review of MBC's decisions. As reflected in Exhibit V-D below, during 2004–05 MBC cut that overall average time slightly to 2.5 years, even without the addition of new monetary resources or staffing; for that, MBC should be commended. However, 2.5 years is still excessive in light of the risk of irreparable harm posed by incompetent or impaired physicians, and the Board's investigative time still far exceeds the 180-day goal established in statute.[87]

[86] *Initial Report*, *supra* note 13, at 63–72.

[87] Bus. & Prof. Code § 2319; *see supra* note 18.

Ex. V-D. FY 2003–04 / 2004–05 Average Complaint Processing Time

	FY 2003–04	FY 2004–05
CCU processing	79 days[88]	66 days[89]
Field investigations (including expert review)	261 days[90]	259 days[91]
HQE prior to accusation filing	107 days[92]	116 days[93]
HQE post-filing/ OAH hearing and proposed decision/ DMQ review and decision	513 days[94]	473 days[95]
TOTAL TIME TO FINAL DMQ DECISION	**960 days = 2.63 years**	**914 days = 2.5 years**

Source: Medical Board of California

2. MBC resources are inadequate.

In the *Initial Report*, the Monitor described the devastating combination of blows suffered by the Medical Board's enforcement program over the past decade, including an outdated license fee structure wherein its fees have been frozen for twelve years, the higher costs of staff salaries (including benefits, pensions, and workers' compensation) and other enforcement-related services (including an increase in the Attorney General's hourly rate) during that time, and significant staffing losses endured by both MBC and HQE as a result of the 2001–04 state hiring freeze. These financial losses and staffing cuts required MBC to disband two promising proactive enforcement programs, cut employee training, reduce work hours for its district office medical consultants, and impose caseloads on some of its supervising investigators. In 2004, MBC estimated that it would need an increase in licensing fees from $610 to $800 biennially to support a restoration of service levels comparable to 1994, and the Monitor agreed.[96]

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[88] *Initial Report*, *supra* note 13, at 99 (Ex. VI-H).

[89] *See infra* Ex. VI-C.

[90] *Initial Report*, *supra* note 13, at 125 (Ex. VII-A).

[91] *See infra* Ex. VII-A.

[92] *Initial Report*, *supra* note 13, at 167 (Ex. IX-B).

[93] Medical Board of California, *2004–05 Annual Report* (Oct. 1, 2005) at vi.

[94] Medical Board of California, *2003–04 Annual Report* (Oct. 1, 2004) at vi.

[95] Medical Board of California, *2004–05 Annual Report* (Oct. 1, 2005) at vi.

[96] *Initial Report*, *supra* note 13, at 72 (Recommendation #2).

In SB 231 (Figueroa), the Legislature responded by amending Business and Professions Code section 2435 to increase MBC's initial and biennial renewal licensing fees to a base of $790 (or $395 per year). Additionally, and as described above in Chapter IV, the Legislature has authorized MBC to exceed the $790 base to recoup lost cost recovery revenue (approximately $850,000 per year, or about $18 per licensee) and to cover increased enforcement activity due to the absence of cost recovery. Finally, in anticipation of the transfer of MBC's investigators to HQE in 2008, new section 2435.3 authorizes MBC to increase licensing fees by an additional $20 per biennial renewal period to cover the costs of the transfer. In order to increase fees above the base of $790 for these reasons, MBC must engage in the public rulemaking process.

According to MBC Executive Director Dave Thornton, SB 231's fee increase will enable the Board to restore fifteen investigator positions, six DAG positions, and MBC's Medical Director position — all of which were lost in the hiring freeze. The fee increase will also allow MBC to implement vertical prosecution, augment the staffing of the chronically understaffed Diversion Program, maintain an adequate budget for the payment of qualified expert reviewers, restore lost medical consultant hours, and maintain a two-month reserve fund as required by law.

The resources battle is only halfway won. Collecting increased licensing fees is one thing; being authorized to spend them is quite another. Armed with the fee increase, MBC and HQE must now submit budget change proposals (BCPs) to restore their lost positions and spend the new money in a way that not only restores 1994 service levels but significantly improves on them. Although MBC has achieved slight improvements in certain categories during 2004–05, the status quo is still unacceptable. Today, MBC's enforcement program staff consists of 20 fewer positions than it had in 1991–92, when it received 22% fewer complaints and took 75% fewer disciplinary actions. As reflected in Exhibit V-D above, the case processing times of MBC and HQE are simply too long to protect the public from dangerous physicians who pose a risk of irreparable harm. Since the hiring freeze ended on June 30, 2004, the number of state employee positions — including those funded by the general fund and by special funds — has grown by an estimated 3.2%.[97] MBC is a special fund agency that requires no money from the general fund, that now has sufficient funding to reinstate its lost enforcement positions and make the other reforms suggested by the Monitor, and that — according to the Legislature and Governor who enacted SB 231 (Figueroa) — "performs one of the most critical functions of state government."[98] The Monitor urges the Department of Consumer Affairs, the Department of Finance, and other control agencies to approve these vitally important BCPs.

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[97] Office of the Governor, *Governor's Budget Summary 2005–06* (Jan. 10, 2005) at Schedules 4 and 6.

[98] Gov't Code § 12529.6(a), as added by SB 231 (Figueroa), 2005 Cal. Stat. 674, § 28.

3. MBC and HQE's management structure and information systems need improvement.

In the *Initial Report*, the Monitor expressed concerns about several aspects of MBC's management structure and information systems. Some of these concerns have been addressed in 2005:

■ ***Medical Director position***. As noted above, MBC lost its Medical Director position in the hiring freeze. The most recent occupant of that position played an important role by assisting the Board and its staff in policy and program development, serving as a liaison to health care constituencies, and working with those constituencies to define issues of importance. In the *Initial Report*, the Monitor urged MBC to reinstate the Medical Director position. MBC agrees, and can fund the new position with SB 231's fee increase. The Monitor urges the Administration to reinstate this important position.

■ ***Diversion Program management***. In Chapters V and XV of the *Initial Report*, the Monitor noted that, for many years, the Medical Board permitted its Diversion Program to effectively function in a vacuum, separate from overall MBC management. This separation resulted in breakdowns in key Diversion functions that pose a risk not only to the public but also to the physicians participating in the Program — breakdowns of which MBC management was not aware and thus could not address. The Monitor recommended that the administration of the Diversion Program be more fully integrated into MBC management. MBC has made progress on this issue. Since the issuance of the *Initial Report*, MBC management has hired a new program administrator who has strong enforcement and impairment program credentials, added a new case manager supervisor position to the Program, and expanded its essential Collection System Manager position into a full-time position. Additionally, new Board President Ronald Wender has created a new Diversion Committee chaired by Martin Greenberg, Ph.D., and Dr. Greenberg is committed to addressing longstanding policy issues that have plagued the Diversion Program. These positive developments are described more fully in Chapter XV below.

■ ***Relationship between MBC and HQE***. As described in the *Initial Report*, MBC's investigations and prosecutions are inefficiently fragmented between two agencies, whereas most other comparable law enforcement agencies employ both investigators and prosecutors who work together in "vertical prosecution" teams under the direction of the prosecutor to gather evidence, assess the strength of the case, and quickly close weak cases while focusing expedited attention on meritorious cases. The 1991 addition of Government Code section 12529 *et seq*. was the first attempt at vertical prosecution; SB 231 goes a step further by imposing the essential elements of vertical prosecution on MBC and HQE — early assignment of an attorney/investigator team, continuity of

teamwork throughout the life of a case, and early designation of trial counsel under whose direction the investigation proceeds. While SB 231 did not succeed in transferring MBC's investigators into HQE for full implementation of vertical prosecution, it has set the stage for the transfer (including the funding), and the Monitor expects the transfer to occur in 2008 after completion of this transition period. These issues, and the precise way in which MBC/HQE plan to implement SB 231's version of vertical prosecution during the transition period, are discussed more fully in Chapters VII and IX below.

■ ***Enforcement policy/procedure manuals***. In researching the *Initial Report* during 2004, the Monitor scoured a dozen MBC policy and procedure manuals, and found that several had not been updated to reflect 2002 legislative changes. The *Diversion Program Manual* had not been revised since 1998, and HQE had no policy and procedure manual whatsoever. MBC has made progress in this area as well. In late 2004, MBC's *Expert Reviewer Guidelines* were revised to correct several factual and legal errors. During 2005, the Monitor has received numerous updates to the Board's *Enforcement Program General Operations Manual, Enforcement Operations Manual, Central Complaint Unit Procedure Manual, Probation Operations Manual*, and *Investigation Activity Report Intranet Users' Guide*. MBC's *Citation and Fine Program Procedure Manual* was completely rewritten and an overhaul of the *Diversion Program Manual* is under way.

HQE has drafted an outline of a policy and procedure manual. However — as described more fully in Chapter VII below — the Monitor believes the better course is for a special working group of MBC and HQE managers to convert MBC's *Enforcement Operations Manual* (EOM), which guides all investigative procedures, into a joint MBC/HQE policy and procedure manual which implements vertical prosecution — both as it is currently mandated by SB 231 and in preparation for the eventual transfer of MBC investigators into HQE. The production of a joint manual would be an excellent first step in encouraging MBC/HQE teamwork and coordination, and would address the *Initial Report*'s concern that many MBC policy and procedure manuals — of which the EOM is the most important — are not systematically reviewed or approved by HQE.[99] MBC has taken a significant step toward achievement of this necessary and important goal by sharing its EOM with HQE management.

■ ***Management information systems***. Like all Department of Consumer Affairs agencies, MBC continues to struggle with DCA's "Consumer Affairs System" (CAS) mainframe computer program, which is so antiquated that the Department is reluctant to support further upgrades to it. Because CAS fails to meet its needs, MBC is forced to track some information manually or with additional small database programs.

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[99] *Initial Report*, *supra* note 13, at 120 (Recommendation #21), 148, 152 (Recommendation #27).

MBC is fortunate to have an in-house Information Systems Branch (ISB) that is capable of designing new software to accommodate specialized programs. After the Monitor expressed concerns in the *Initial Report* about the error-ridden Diversion Tracking System (DTS) utilized by the Diversion Program, ISB revamped the DTS into a Web-based real-time program that was operational by July 1, 2005. This issue is discussed in more detail in Chapter XV below.

HQE now has one year of experience with its new ProLaw case management system, which is used to track attorney time and tasks performed on MBC cases, produce itemized billings for client agencies, and produce various types of reports that enable HQE managers to better supervise line DAGs and their movement of cases. HQE and its prosecutors appear to have mastered the case tracking system aspect of ProLaw in that all HQE attorneys (since July 14, 2004) now track their time and tasks performed on MBC cases on ProLaw. Additionally, HQE managers have begun to request and receive simple reports (for example, detailed billing reports by case and/or by prosecutor, and detailed case aging reports that provide clear and helpful information regarding key dates in the life of any case) that enable them to better supervise their staff.

However, HQE appears to have made less effective use of other important capabilities of this system. For example, ProLaw has a calculation function which would allow HQE to track sectionwide average time from its acceptance of cases to accusation filing, average time from filing to the date of stipulation and/or first date of hearing, and average caseloads of HQE DAGs. However, either HQE has not requested that the calculation function be activated or its external ProLaw contractor has not provided that service. As a result, HQE managers either don't know these calculated averages or must compute them on standalone databases in Access or Excel. Additionally, ProLaw does not classify cases by priority pursuant to Business and Professions Code section 2220.05; although the Monitor was told in 2004 that the addition of this field would be an "easy fix," it has not been accomplished. The Monitor recommends that HQE take full advantage of its new ProLaw system by learning its capabilities, activating the calculation function, and ensuring the data needed to calculate desired averages or totals are properly input by HQE staff on all cases.

Additionally, the Monitor recommends — as described more fully in Chapter VII below — that MBC purchase ProLaw, train its investigators in its use, and require investigators to track their time and activities on ProLaw as of January 1, 2006 (or as soon as is practicable thereafter). As vertical prosecution goes online as of January 1, 2006, and in preparation for the transfer of MBC's investigators to HQE in 2008, both sets of professionals should use the same computer system to track their time and activities on MBC cases. Both sets of professionals should be consistently trained in the use of that system, and both agencies should agree to and begin to use the same terminology and methodology in describing activities, events, and timeframes in their jointly-worked

cases. As described in Chapter IX below, MBC and HQE still count cases differently, and they count various timeframe intervals within cases differently.[100] As frustrating as that is for an external auditor like the Monitor, it must be maddening for those who actually work in the system. These two agencies — especially as they begin a process that is intended to integrate key MBC and HQE staff — must begin to work as one, utilizing the same tracking system, terminology, and methodology of counting case cycle times.

C. Recommendations for the Future

■ ***Integrated policy/procedure manual***. As described above and in Chapter VII below, HQE and MBC should work together to convert MBC's excellent *Enforcement Operations Manual* into a joint policy and procedure manual incorporating vertical prosecution.

■ ***Expanded use of ProLaw by HQE***. HQE should master all of the capabilities of ProLaw and ensure that the system is being utilized to its full capacity.

■ ***Use of ProLaw by MBC investigators***. As soon as possible after vertical prosecution goes online on January 1, 2006, MBC investigators should convert to the use of ProLaw. Both agencies should use the same case tracking system, be trained consistently on the use of that tracking system, and begin to count cases and case timeframes in the same way.

[100] *See infra* Ch. IX.B.1. for a discussion of this issue.